NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION
SPORT PREPARTICIPATION EXAMINATION FORM

Patient’s Name: ____________________________________________________________
Age: ___________ Sex: ___________

This is a screening examination for participation in sports. This does not substitute for a comprehensive examination with your child’s regular physician where important preventive health information can be covered.

Athlete’s Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.

Parent’s Directions: Please assure that all questions are answered to the best of your knowledge. If you do not understand or don’t know the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.

Physician’s Directions: We recommend carefully reviewing these questions and clarifying any positive or don’t know answers.

Explain “Yes” answers below

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
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1. Does the athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:
2. Is the athlete presently taking any medications or pills?
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?
4. Does the athlete have the sickle cell trait?
5. Has the athlete ever had a head injury, been knocked out, or had a concussion?
6. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?
7. Has the athlete ever passed out or nearly passed out during exercise, emotion or startled?
8. Has the athlete ever fainted or passed out after exercise?
9. Has the athlete ever had extreme fatigue (been really tired) with exercise (different from other children)?
10. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?
11. Has the athlete ever been diagnosed with exercise-induced asthma?
12. Has a doctor ever told the athlete that they have high blood pressure?
13. Has a doctor ever told the athlete that they have a heart infection?
14. Has a doctor ever ordered an EKG or other test for the athlete’s heart, or has the athlete ever been told they have a murmur?
15. Has the athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart “racing” or “skipping beats”?
16. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?
17. Has the athlete ever had a stinger, burner or pinched nerve?
18. Has the athlete ever had any problems with their eyes or vision?
19. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?
   - Head
   - Shoulder
   - Thigh
   - Neck
   - Elbow
   - Knee
   - Chest
   - Hip
   - Forearm
   - Shin/calf
   - Back
   - Wrist
   - Ankle
   - Hand
   - Foot
20. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?
21. Has the athlete ever been hospitalized or had surgery?
22. Has the athlete had a medical problem or injury since their last evaluation?

FAMILY HISTORY

23. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?
24. Has any family member had unexplained heart attacks, fainting or seizures?
25. Does the athlete have a father, mother or brother with sickle cell disease?

Elaborate on any positive (yes) answers: ____________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

By signing below I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in sports.

Signature of parent/legal custodian: ____________________________________________ Date: ________________

Signature of Athlete: ____________________________________________ Date: ________________ Phone #: _________
Physical Examination (Must be Completed by a Licensed Physician, Nurse Practitioner or Physician’s Assistant)

Athlete’s Name ______________________________ Age ________ Date of Birth _____________

Height ________ Weight ________ BP ________(_____% ile) / ________(_____% ile) Pulse ________

Vision R 20/ ________ L 20/ ________ Corrected: ☐ Y ☐ N

These are required elements for all examinations

<table>
<thead>
<tr>
<th></th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
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<tbody>
<tr>
<td>PULSES</td>
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<td>HEART</td>
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<td>LUNGS</td>
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<td>SKIN</td>
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<td>NECK/BACK</td>
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<td>SHOULDER</td>
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<td>KNEE</td>
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<td>ANKLE/FOOT</td>
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<td>Other Orthopedic Problems</td>
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Optional Examination Elements – Should be done if history indicates

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<td>HEENT</td>
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<td>ABDOMINAL</td>
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<tr>
<td>GENITALIA (MALES)</td>
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<tr>
<td>HERNIA (MALES)</td>
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Clearance**:

☐ A. Cleared
☐ B. Cleared after completing evaluation/rehabilitation for: __________________________
☐ C. Not cleared for: ☐ Collision ☐ Contact ☐ Non-contact ☐ Strenuous ☐ Moderately strenuous ☐ Non-strenuous

Due to:
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

Additional Recommendations/Rehab Instructions: __________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

Name of Physician/Extender: ______________________________

Signature of Physician/Extender __________________ MD DO PA NP

(Signature and circle of designated degree required)

Date of exam: __________________________

Address: ______________________________________

Phone ________________________________

Physician Office Stamp:

(** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of convulsions or concussions, absence of one kidney, eye, testicle or ovary, etc.)

This form is reviewed annually, and was last updated April 2012.

This form is approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee and the NCHSAA Board of Directors.